DELAWARE DIVISION OF FISH & WILDLIFE

VERIFICATION OF DISABILITY TO HUNT WITH A CROSSBOW

Via completion of this form in full by the applicant and by a licensed physician and upon submission of this original form to the Wildlife Section, Delaware Division of Fish and Wildlife, 89 Kings Highway, Dover, Delaware, 19901, holders of this fully completed application form are authorized to use a crossbow for the life of the permittee unless revoked. This permit can only be issued if it is signed by a medical doctor to certify that the applicant is unable to use archery equipment. The Division reserves the right to test applicants to see if they meet the criteria of disability and to revoke the permit upon violation of any wildlife law related to the use of a crossbow or unlawful hunting of deer. **All sections must be completed.**

APPLICANT'S CERTIFICATION

Name: _____ Social Security No. _____

Address: _____ City:_____

County: _____ State: _____ Zip code:_____

Telephone number: _____ Date of birth: _____

I hereby certify that I have read and understood the regulation on hunting with a crossbow.

Applicant's Signature: _____ Date: _____

PHYSICIAN'S CERTIFICATION

Listed below are the criteria that the Division accepts for the issuance of special permits to allow disabled hunters to use a crossbow to hunt deer during the archery season in Delaware.

1. Is the applicant fully confined to a wheelchair? **(Check One)** □ **YES** □ **NO**

2. Is the applicant a single or double amputee above the elbow, or be a double amputee below the elbow? □ **YES** □ **NO**

3. Does the applicant suffer from lung disease to the extent that forced (respiratory) expiratory volume for one second when measured by spirometer is less than one liter or arterial oxygen tension(po) is less than 60 mm/Hg on room air at rest? □ **YES** □ **NO**

4. Does the applicant have a permanent physical disorder which cannot be surgically corrected and prevents the use of an arm or hand? □ **YES** □ **NO**

5. Is the applicant impaired by cardiovascular disease to the extent that functional limitations are classified in severity as class III or class IV according to standards accepted by the American Heart Association? □ **YES** □ **NO**

6. Please provide a written description of the patient's disability below:

_____

_____

_____

Printed Name of Physician: _____

Office address: _____

Office phone: _____

I certify, via my signature, that the information provided on this form is true, complete and correct to the best of my knowledge and made in good faith.

Physician's Signature: _____ Date: _____

THIS PERMIT IS VALID FOR THE LIFE OF THE PERMITTEE UNLESS REVOKED.

_____ _____

Eugene Greg Moore, Wildlife Administrator Date